INSURE MONTANA

INSURING MONTANANS ONE SMALL BUSINESS AT A TIME

Employee Premium Assistance Deposit Opt-In

By completeing this form, employees are agreeing to have their premium assistance payments go directly to the employer.

Business Name:_____

Employer Bank Information: **ATTACH A VOIDED CHECK TO THIS FORM. (Do not send deposit slips)**

Name on Account: _____

Transit Routing Number (9 digits): _____

Bank Account Number (include zeros, do not include check number): _____

Type of Account (select only **one**): ____ Checking ___ Savings

Date Bank Account Opened: _____/_____/_____

Financial Institution Name: _____

Bank Address: _____

City: _____ State: _____ Zip: _____

Bank Phone Number: _____ Ext: _____

Deposit my premium assistance payments directly into my employer's account.

***NOTE: By agreeing to have premium assistance payments deposited in your employer's account, you are agreeing to allow your employer to learn the amount of the premium assistance subsidy you receive each month.)*

1. Employee Name (print name):
Employee Signature: Date:
2. Employee Name (print name):
Employee Signature: Date:
3. Employee Name (print name)
Employee Signature: Date:
4. Employee Name (print name):
Employee Signature: Date:
5. Employee Name (print name):
Employee Signature: Date:

This agreement can be nullified by notifying Insure Montana in writing that you no longer want to Opt-In. All changes will take effect on the next scheduled payment.